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Anger over RPSGB practising fee hike

Dawn Primarolo:
our exclusive
interview continues

- CPD: four case studies on treating atrial fibrillation
- Ethical scenario: methadone patient gets two supplies

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levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack



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of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

4. Coe JW. J Med Chem 2005; 48:3474-3477. 5. Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.

CHA055b
Date of preparation: Nov 2006

Adverse events should be reported to Pfizer Medical Information on 01304 616161.
Information about adverse event reporting can also be found at www.yellowcard.gov.uk

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55.
2. Jorenby DE *et al.* JAMA 2006; 296:56-63.
3. Tonstad S *et al.* JAMA 2006; 296:64-71.

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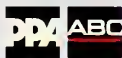
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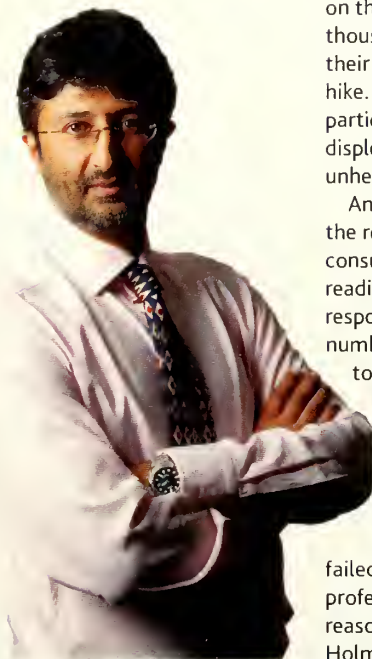


Chemist+Druggist

news • education • tools for the pharmacy community

Comment from the Editor

“The Society has spectacularly failed to win support from the profession”



So now we know. From January, pharmacists will pay an eye-watering £395 for the privilege of working in their chosen profession. Whether you work a few hours a week, a few days a month or full time, you will pay the same fee. Perhaps we should count ourselves lucky – after all, Lambeth had originally proposed a £425 levy.

The rise – a 40 per cent increase on this year – comes despite thousands of members expressing their opposition to the proposed hike. The online petition in particular saw 10,000 register their displeasure, a level of response unheard of among pharmacists.

And the independent analysis of the responses to the fee consultation doesn't make for easy reading for Council. To quote: "The responses contained a large number of comments...[intended to] express a general and deeply felt dissatisfaction with the Society. Some of these were expressed in what might be politely termed vigorous language..."

The Society has spectacularly failed to win support from the profession despite setting out the reasons for such a rise. For Jeremy Holmes, the new RPSGB chief

executive, the honeymoon period is over and he needs to find the magic formula to win back pharmacists' confidence. In just two years' time, membership of the RPSGB will become voluntary, and pharmacists could choose to leave in droves.

But where will that leave the profession at a time when pharmacists in all sectors are finally being recognised as key members of the national health service, and with the promise of new and expanded roles on the horizon? Who will, as the Charter says, safeguard, maintain the honour and promote the interests of pharmacists?

With the fee imposition occupying the profession's collective thoughts for the foreseeable future, the Society's Clarke Inquiry into what the profession wants from a future professional body could not be more timely.

If pharmacists are disaffected by their leadership, now is the time to speak up. And those heading the inquiry need to take those views on board, no matter how unpalatable. Otherwise, as Sandra Gidley says (p16) we could be marching into oblivion.

Gary Paraguri, Editor

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Practising fee up 40 per cent

Partial climb-down as RPSGB shelve plans for 50 per cent hike in retention fees for practising pharmacists

Jennifer Richardson

The Royal Pharmaceutical Society has announced a 40 per cent increase in the practising pharmacist retention fee, from this year's £283 to £395 in 2008.

This represents a partial climb-down for the Society, which in July proposed an increase of 50 per cent to £425. The change follows a two-month consultation, which received 1,145 responses and an online petition that gained 10,000 signatures in a fortnight.

RPSGB treasurer Andrew Gush said the lower increase was possible due to the freeing up of £500,000. "Further work had been done to identify potential budget savings," he said.

These included discussions with staff and pension trustees, leading to the expected reduction of the pension deficit and the benefits the fund provides.

The Society also hired an adviser who enabled it to reduce by £250,000 the £1 million bill resulting from tax changes that reduced its ability to pass liabilities to charity as Gift Aid.

Asked why these measures had not been taken earlier, Mr Gush said: "When we made the initial proposal of a 50 per cent increase this was at the beginning of our budget cycle so we were dealing with very loose conservative figures."

Correspondingly lower increases will apply to other registration fees, with some exceptions for which the Society has reduced the impact further.

These include fees for non-practising pharmacists, who see an increase of less than 5 per cent, and overseas pharmacists, which have been raised only in line with inflation.

Mr Gush said: "We recognise the impact of the fee change on members and have responded to feedback by lessening the impact on those groups who may have found the increase most difficult."



Andrew Gush: Society has saved £500,000 from budget review

What is your view on the fee rise?
haveyoursay@cmpmedica.com

Fears of pharmacists quitting

A number of RPSGB Council members expressed concerns over the revised 2008 fees, despite the proposals being passed by an overwhelming majority vote.

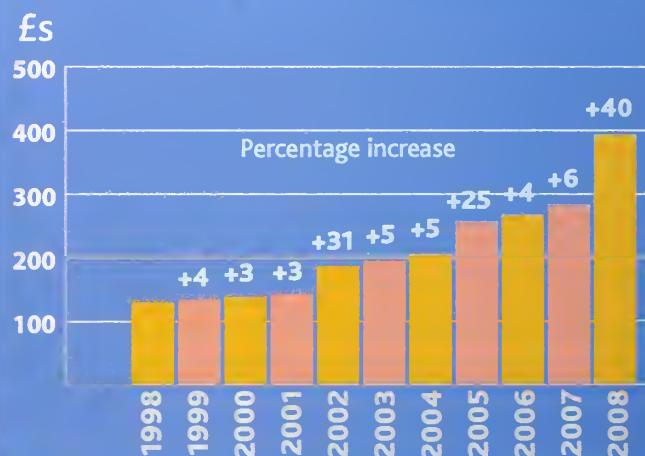
Four members voted against the proposals to increase the practising pharmacist retention fee by 40 per cent, and there were two abstentions.

Before the vote, Gerald Alexander said "potentially large" numbers of pharmacists could leave the register as a result of the increase. "I would have

preferred to see increases take place over a longer period," he said. But Mr Alexander added he felt "duty bound" as a Council member to support the proposals.

Another member echoed Mr Alexander's concerns about the impact on future membership to the Society as an optional leadership body once it lost its dual role also as a regulator. "When it is no longer compulsory to join, the professional body will be in a competitive market," she said. JR

2008 fee facts



Consultation reveals 'deep dissatisfaction' with RPSGB

An independent analysis of 1,145 responses to the Royal Pharmaceutical Society's 2008 fees consultation has revealed "deep dissatisfaction" with the organisation as a whole.

Independent analyst Anthony Harrison said the number of responses and "lack of substantive variation" meant the Society could be "confident that the views of the membership have been accurately expressed".

Ninety nine per cent of respondents objected to the RPSGB's increase in retention fees, but Mr Harrison said many had also used the consultation to "express a general and deeply felt dissatisfaction with the Society".

He said: "Some of these were expressed in what might be politely termed vigorous language."

These included comments taken from a 10,000-strong online petition against the proposed 50 per cent fee hike that was considered as part of the analysis.

Mr Harrison noted that respondents felt the Society was "not adequately in touch with its members". RPSGB president Hemant Patel agreed: "It's true. I regret it as president of the Society but I think that will not last forever."

He added: "There's a clear duty on members to let the Society know what they expect of us... if people are unhappy they should

immediately write to the president."

Mr Patel was "saddened" by the fact that more than a quarter of respondents thought the Society was poor value for money, but understood their feelings. The Society was under government pressure leading to 87 per cent of expenditure going towards regulation and limiting its ability to invest in services, he said.

About a third of respondents were critical of the consultation questionnaire itself. Mr Patel put this down to the Society's lack of experience in producing such a document and said members' views would be taken into account in future consultations. JR

1,145
people responded

99%

of respondents objected to the proposed 50 per cent rise

4/5

respondents did not agree with the principles of fee setting

58%

of respondents said registrants should not bear the costs of a Society pension deficit

1/3

respondents criticised the consultation document

Discount fails to ease anger over price hike

Pharmacists remain fiercely opposed to the Royal Pharmaceutical Society's revised retention fees structure, according to a C+D straw poll.

The RPSGB's move to drop the increase in retention fees from 50 to 40 per cent had failed to win over the profession, early feedback indicated.

James Powell, owner of Medicine Man mobile pharmacy, said: "If pharmacists thought they were getting value for money they would be happy to pay it but I don't think any of us believe that we are."

Others, although not happy, think the increase is sustainable. Remesh Raghubeer of St Clare

Chemists, Croydon, said: "It's a massive increase. I think everybody will be able to pay quite comfortably but they'll resent the rise."

John Murphy, of the Pharmacists' Defence Association, fears the increase will hit part-time pharmacists working fewer than 10 hours a week. Mr Murphy said: "The Society is penalising a key group who support the labour shortages at crucial times of the year."

Opposition also extended to Scotland. A Glasgow pharmacist, who wished to remain anonymous, said: "It doesn't really matter if it's 40 per cent or 50 per cent. It's still a ridiculous amount of money." **JC**

Pharmacist retention fee – practising: **£395 (+£112)**

Pharmacist/technician retention fee – non-practising: **£67 (+£3/-£4)**

Supplementary/independent prescriber application: **£49 (+£14)**

Upgrade – non-practising to practising: **£328 (+£109)**

Technician retention fee – practising: **£130 (+£37)**

Pre-reg training fee: **£160 (+£7)**

Pre-reg exam fee: **£180 (+£9)**

Source: RPSGB

Multiples count the cost

The 40 per cent hike in the practising pharmacist retention fee could cost the largest pharmacy companies as much as £450,000 extra next year.

Most multiple chains pay Royal Pharmaceutical Society registration fees for their employees. Boots, Lloydspharmacy and the Co-operative group confirmed this support, but declined to reveal the total cost of the increase. A Boots spokesperson said the company was "discussing the impact".

However, the big three did confirm the approximate number of registered, practising pharmacists they currently employ. From these figures, C+D has estimated that the 2008 headline

fee could cost Alliance Boots £1,580,000, an increase of £448,000 on this year's bill.

The relative estimated amounts for Lloydspharmacy are an increase of over £220,000 to £790,000. The Co-operative Group could face a bill of almost £300,000, up £84,000. Increases in fees for other employees will add to these amounts.

Small independent multiples also faced added financial pressure from the fee rise, the Association of Independent Multiple Pharmacies' chief executive Roy Carrington said.

He anticipated many independent multiples paying only for the compulsory regulatory body when the RPSGB lost its dual role. **JR**

Grassroots VERDICT

The C+D news team took to the streets of London this week and conducted a straw poll of 12 pharmacists, all of whom gave the same answer

Is the revised retention fee value for money?

Yes

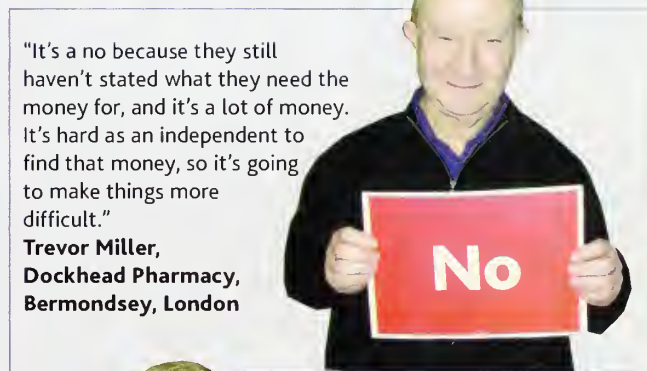
No



"It's outrageous. It's unjustifiable. It's a sledgehammer to crack a nut. I think it shows imprudence from the Society in how they've handled their finances.

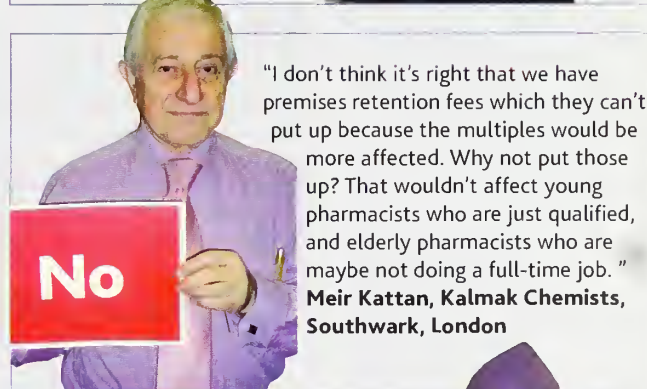
They've chosen to put money into the charitable foundation instead of paying a little bit of corporation tax and making up the pension deficit."

Yogendra Parmar, Makepeace Pharmacy, Sydenham



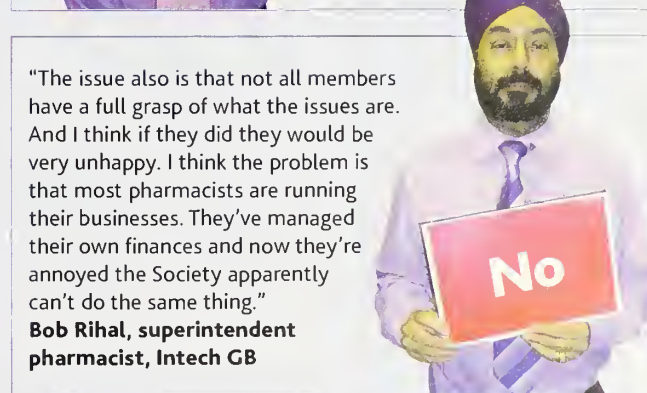
"It's a no because they still haven't stated what they need the money for, and it's a lot of money. It's hard as an independent to find that money, so it's going to make things more difficult."

Trevor Miller, Dockhead Pharmacy, Bermondsey, London



"I don't think it's right that we have premises retention fees which they can't put up because the multiples would be more affected. Why not put those up? That wouldn't affect young pharmacists who are just qualified, and elderly pharmacists who are maybe not doing a full-time job."

Meir Kattan, Kalmak Chemists, Southwark, London



"The issue also is that not all members have a full grasp of what the issues are. And I think if they did they would be very unhappy. I think the problem is that most pharmacists are running their businesses. They've managed their own finances and now they're annoyed the Society apparently can't do the same thing."

Bob Riha, superintendent pharmacist, Intech GB

Dispensary TALK

The Pope has asked Catholic pharmacists not to dispense EHC. Do you agree?



"The ethical guidelines of the Society say it's OK as long as you direct them to the next nearest place. But it should definitely remain a professional rather than a religious issue."

Mukesh Shah, C Goode Pharmacy, Middlesex



"I think he was right to say that if that's what he believes. It's a matter of religious preference and people should always be allowed to express their beliefs."

Kay Crockatt, Co-op Pharmacy, Hartlepool

WEB VERDICT:

Yes: ☐ 14%

No: ☒ 86%

Armchair view: Religion and pharmacy don't seem to mix. Pope Benedict XVI's plea fell on deaf ears as a whopping 86 per cent of pharmacists voted against the Vatican.

This week we're putting your faith in the Royal Pharmaceutical Society to the test – do you think its revised 40 per cent increase in prescription fees is reasonable?

Write in: www.chemistanddruggist.co.uk

PSNC pension costs double

One-off £250,000 payment made to ensure scheme is 'properly funded'

Pension costs at PSNC doubled in 2007 as the contract negotiator made a one-off £250,000 payment to steady the scheme's shortfall.

PSNC's annual report revealed this year's pension costs stand at £762,575 compared to £376,762 in 2006.

The organisation made a further provision of £250,000 towards the pension scheme on top of the one-off £250,000 payment, figures revealed. A PSNC spokesman said: "The payments are needed to ensure that the scheme is properly funded. This scheme has a deficit and PSNC has an obligation to make this good."

PSNC operates the pension scheme in partnership with the NPA. The scheme closed to new members in 2000. Staff joining before this date could join the NPA final salary scheme, PSNC confirmed.

"PSNC is working with the NPA to remove this deficit, largely through seeking economies in operations," the spokesman added.

Staff costs also increased at PSNC in 2007, the annual report showed. Payments increased to £267,565 with employees' expenses bills up by £47,097 this year. However, PSNC recorded a

£37,400 reduction in property costs and a £12,550 saving on printing, stationery, postage and telephone bills.

PSNC increased cash and bank balances by £463,692 to £537,074 figures revealed.

PSNC chief executive Sue Sharpe said the organisation had worked towards supporting the development of pharmacy services in 2007. Medicines use reviews had been a particular focus, she said.

The industry had been adversely affected by Pfizer's DTP deal and the "sorry" transfer of domiciliary oxygen away from contractors, Ms Sharpe added. **MG**

Draft GPhC legislation heads for parliament

Draft legislation on a new pharmacy regulator could reach parliament as early as this month.

England's chief pharmaceutical officer Keith Ridge said the timescale for this landmark in the establishment of a General Pharmaceutical Council (GPhC) was "likely".

His comments came as PRLOG, the steering group charged with advising the government on the GPhC's establishment, of which Dr Ridge is a member, prepared to meet for the second time.

The demerger of the Royal Pharmaceutical Society into the GPhC and a proposed royal college was an "historic moment" for the profession, Dr Ridge said.

He added: "It will offer the opportunity for pharmacy to come together to develop a strong leadership body." **JR**



England's chief pharmaceutical officer Keith Ridge opened the University of Hertfordshire's mock pharmacy, which is home to a robotic dispensary, on Monday. Professor Soraya Dhillon, head of the School of Pharmacy, said: "Students being exposed to the latest technology and being able to provide services using it is crucial to the MPharm degree"

Pharmacy lessons for primary schools

A pharmacist and NPA staff faced a classroom of primary school children this week to mark 2007's Ask About Medicines Week.

Steve Brill, a community pharmacist from St Albans, led a lesson on the safe and effective use of medicines, which included colouring in pictures of pharmacists.

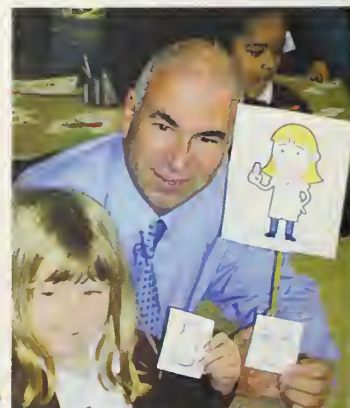
The theme for the week (November 3-9) was asking about medicines as we grow up. Healthcare professionals were encouraged to take part using

resources available online to help them plan lessons and educate school children about medicines.

Mr Brill said he wanted to take part because he believed his role as a pharmacist was important, and he wanted children to understand it. He said: "I think they have more of a concept of what a pharmacist is now." **ZS**

www.askaboutmedicines.org

How did you mark Ask About Medicines Week?
zsmeaton@cmpmedica.com



Steve Brill: children now have a clearer idea of the role of a pharmacist



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News in brief

Nucare offer extended

Phoenix requires just a further 6 per cent of Nucare shares for its bid for the symbol group to be formally accepted. Phoenix's cash offer was recommended by the Nucare board, and had received valid acceptance for almost 84 per cent of shares. The offer has been extended to November 19.

OFT Christmas gift

The Office of Fair Trading will publish its study into NHS drugs distribution before Christmas, C+D has learnt. The competition watchdog is due to report on the impact of the Pfizer DTP deal and other manufacturer-led supply changes by the end of this year.

Diabetes hot spot

People in Slough have the highest risk of developing diabetes in the country, according to research by Lloydspharmacy. According to the study, one in 40 adults in the town has a 'very high' blood sugar reading, in contrast with the national average of one in 80.

NPA bid on hold

The NPA's £6.4 million purchase of the renewal rights of the Pharmacy Mutual Insurance Company has suffered a setback, C+D understands. The NPA failed to secure the support of 95 per cent of attendees it needed at a meeting this week.

Pseudoephedrine info

UniChem has published a guide to highlighting changes to the regulation of medicines containing pseudoephedrine and ephedrine. The guide is published in a Q&A format and is available via the UniChem customer-facing and commercial teams.

Security awareness

Pharmacists have been urged to find out about local security management services in their PCT, and learn how to report any assaults at their pharmacies, as part of NHS Security Awareness Month this November.

www.cfsms.nhs.uk

GP salaries rise

The average salary of family doctors has risen to £110,000, representing a 50 per cent increase since 2004. The figures come from information from the Department of Health and Social Care.

Electronic clinical data eyed with suspicion

Pharmacists double-checking alerts against printed references

Max Gosney

Many pharmacists refuse to trust electronic clinical data and check PMR alerts against paper references before challenging a prescription, a survey has revealed.

Half of the 100 pharmacists polled query up to five prescriptions a week after a prompt from their PMR system, the survey by Stirling IT consultants revealed.

However, many double check alerts, with print guides such as the British National Formulary proving the most trusted reference tool, the survey found. A quarter of respondents voiced doubts over the quality of PMR clinical data, with 13 per cent ignoring all alerts in favour of their own "experience".

Geoff Mackay, director of Stirling Consultants, commented: "They're going away and double checking the alerts against additional and, at

times, out of date resources.

"With the clinical focus of the new contract and ever increasing script volumes, do pharmacists really have the time to spend on this?"

However, despite an apparent bout of technophobia, pharmacists do appear to recognise the value of electronic data. Eighty per cent of pharmacists said clinical data will grow in stature over the next five years, with 72 per cent currently using PMR data for MURs.

Mr Mackay urged improved training packages to boost pharmacists' confidence with computer data. IT suppliers must also adopt quality standards for PMR clinical data, he added.

No room for technophobes – see Geoff Mackay's comment at www.chemistanddruggist.co.uk

Clinical data by numbers

71%

said drug interactions are the most important clinical alert provided by their PMR.

600,000

estimated number of times a week pharmacists take action as a result of a PMR alert.

13%

of pharmacists ignore all PMR alerts in favour of trusting "their experience".

5%

of pharmacists validate alerts through Google.



Striker pose: former Spurs and England football star Gary Lineker tried out a spirometer at the launch of Lung Cancer Awareness month last week. Events are taking place throughout November with the campaign message that "early diagnosis saves lives". The location for the launch, White Hart Lane, home to Tottenham Hotspur FC, has a capacity of 37,000 – almost equal to the number of people diagnosed with lung cancer each year in the UK

Scope to embrace PBC, despite slow start

Just one third of GP practices in England have commissioned services through practice-based commissioning, according to an independent survey commissioned by the Department of Health.

And while 57 per cent of GPs say they are supportive of the policy, only 13 per cent think PBC has improved patient care.

But NPA NHS liaison manager Gareth Jones said pharmacists could not afford to ignore PBC, despite its slow development. "This survey shows that there is still plenty of scope for community pharmacy to get involved locally at the start of PBC – when opportunities will be at their greatest," he said.

PSNC spokesperson Dipen Shah acknowledged the hurdles pharmacists faced. "In a lot of areas where PBC hasn't taken off it's difficult for pharmacists to get involved," he said.

PBC may need to be reviewed, he added, and the advantages of involving more healthcare professionals considered. **JR**



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Show me

In the second part of an exclusive interview with C+D, pharmacy minister Dawn Primarolo tells [Colin Brown](#) how Whitehall plans to pay for extra pharmacy services

C+D: The government's Comprehensive Spending Review pledged to raise NHS spending over the next three years. Is there scope for a growth in budgets for pharmacy services?

DP: We think the new contract has done very well in providing for that. We have probably got that under our belt in terms of opening up services that can go through pharmacies. We think we are ahead of the curve there. But obviously the discussions will need to be around what emerges from the white paper consultation and Ara's Next Steps NHS review.

It is a good settlement, but we think we are in a good place with the pharmacy contract and we can build on that in the future. That [the pharmacy contract] is the most important framework at the moment.

C+D: What about safeguards to protect pharmacy funding from PCTs?

DP: Both PSNC and the NHS are happy with the safeguards that are in place, which is about setting levels of fees and allowances to community pharmacies in the advanced tier of the contract. But they have slightly different views with regard to enhanced payments.

While obviously there will continue to be discussion about this, the whole point of opening up services and bringing pharmacies into the primary care team is about giving PCTs the opportunity to contract services to pharmacies. I think it is going to work out but there are concerns. There are safeguards and there will continue to be discussions.

C+D: It sounds as though you want flexibility for the PCTs but the direction of travel is towards pharmacies so they should not be concerned about losing money?

DP: I don't think they should be. People have fears. But we are already setting at the other two levels the fees and allowances that are underpinning the system. There are other pressures in the



the money

“I want to send a very strong message that I see the white paper as part of the Next Steps review”

system to make sure that there isn't waste of medicines.

What I am basically saying is that there are concerns in that particular area. It's important to work this through as we are opening up the role for pharmacies, but I think at the moment there are enough safeguards with essential and advanced services having fees and allowances set nationally to keep that in check.

C+D: What do you hope to get out of the consultation on the responsible pharmacist?

DP: That is another part of the broad strategy about how we can ensure we are opening up so we can use the full clinical skills of a pharmacist. People should take comfort – and I hope engage in that consultation – from the fact that is exactly the way we are heading.

C+D: How closely will the pharmacy white paper tie in with Lord Darzi's Next Steps NHS review?

DP: I want to send a very strong message that I see the white paper as part of the Next Steps review.

At the moment I am still looking at whether they need to be [published] at the same time. I don't want to send a signal that makes it look as though pharmacies are not part of Next Steps. Part of Ara's review is looking at clinical decision-making and making sure that is drawing on commissioning and delivery. It's all about being patient-centred but that is what the white paper is going to be doing.

He's also going to be looking – and it crosses over with the pharmacy contributions – to long-term conditions. Some PCTs are looking at not just cessation of smoking, but monitoring of hypertension. There are discussions to have around health checks, how you make sure there is more patient choice, control, local accountability. It seems to me it's crucial that pharmacies have a role there.

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ETP – will it become an electronic nightmare?

ETP could be one of the biggest mistakes we've let ourselves in for. It looks increasingly like release 2 will bring more work and no benefit.

It always takes a while to adjust to any new way of working and I'm sure I'll soon be able to process electronic prescriptions nearly as quickly as their paper equivalents, but I think the electronic process contains a number of flaws. It promised easy operation and a reduction in human error, but I think the opposite could be true.

Repeat prescription labels are usually generated from the PMR history, so creating a double check between what I dispensed last time and what the GP has prescribed now. But electronic prescriptions are simply taken at face value, with no check against what was prescribed or dispensed previously. I still have to select the pack size/brand, enter the quantity, and often clarify the GP's dosage instructions each time an item is repeated. So much for fewer keystrokes.

The paper trail is longer as I have a pile of scripts waiting to be put in alphabetical order and scan, one waiting to be checked and amended against the computer screen, another waiting to be dispensed, and so

on. When paper prescriptions finally disappear, the pile of scripts waiting to be scanned will be replaced with (yet another) printer that will have to check against the screen and the medicines. The printing of prescriptions will have shifted from the GP to the pharmacy.

Then what will exempt patients sign? And what further piece of paper will they use to order their repeat medication? We'll probably end up ordering their repeats too. We will drown in a sea of paper forms.

Chasing the surgery for electronic prescriptions that patients think should have been sent to me could be so time-consuming that I'll need another member of staff. Prescriptions sent to another pharmacy are unlikely to be retrievable and patients will simply have to go and collect them from elsewhere.

All this might be justifiable if I could see any benefit, but an electronic system won't be safer, quicker, more convenient for patients nor better for the environment. At least if I become a responsible pharmacist I can escape from the dispensary, leaving this 'electronic' chaos to my long-suffering staff.

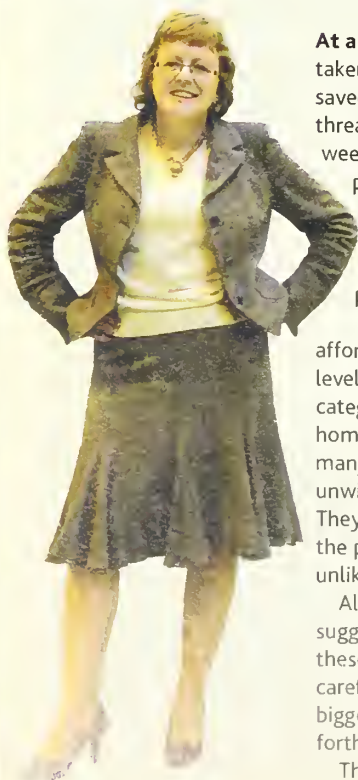
There's definitely money in IT, as borne out by the fact that Google is now worth 30 per cent more than Pfizer. But Google gives its users what they want while Connecting for Health apparently has its own agenda.



Pharmacist in the House

Sandra Gidley

We have to be careful that we do not sleepwalk into oblivion



At a constituency level my time has recently been taken up dealing with threats to local services. We have saved the train and the local hospital but are now facing threats to a vital bus link and a number of post offices. Last week I visited a vulnerable local pharmacy which the local

parish council is also keen to save. It set me thinking and I can't help wondering whether we need to "save" pharmacy at a national level.

As a profession we cannot afford to be complacent. On one level the financial implications of category M are beginning to hit home and there are still far too many pharmacists who seem unwilling to get stuck into MURs. They don't seem to realise that if the profession does not deliver on this, the government is unlikely to offer money for other services in the future.

All this is bad enough but a reading of the runes would suggest that the profession is facing bigger threats. Some of these are not immediately obvious and we have to be careful that we do not sleepwalk into oblivion. The two biggest influences on the future of pharmacy are the forthcoming white paper and Lord Darzi's review.

The word on the street appears to be that the white paper

will suggest that distribution of pharmacies should be planned locally. At one level this can be perceived as recognition that pharmacy is a vital part of the primary care team. At another level alarm bells start ringing because we all know that many PCTs fail to understand pharmacy.

As if that wasn't enough, we have Lord Darzi's review to contend with. The proposed polyclinics are all likely to include a pharmacy and politicians I have spoken to initially think that this is a bonus for pharmacy. They do not understand that this destabilises the local pharmacy network and will put some pharmacies out of business. So what? Well, when you

explain to them that local people, often in the most deprived areas, will have reduced access to health services then they are concerned.

I am not one of those who believes pharmacy has no future but if pharmacy ignores Darzi and the white paper then the face of pharmacy will look very different in the future. Is that what we want?

Sandra Gidley, Lib Dem MP and shadow health spokesperson

“ I wonder whether we need to 'save' pharmacy at a national level? ”

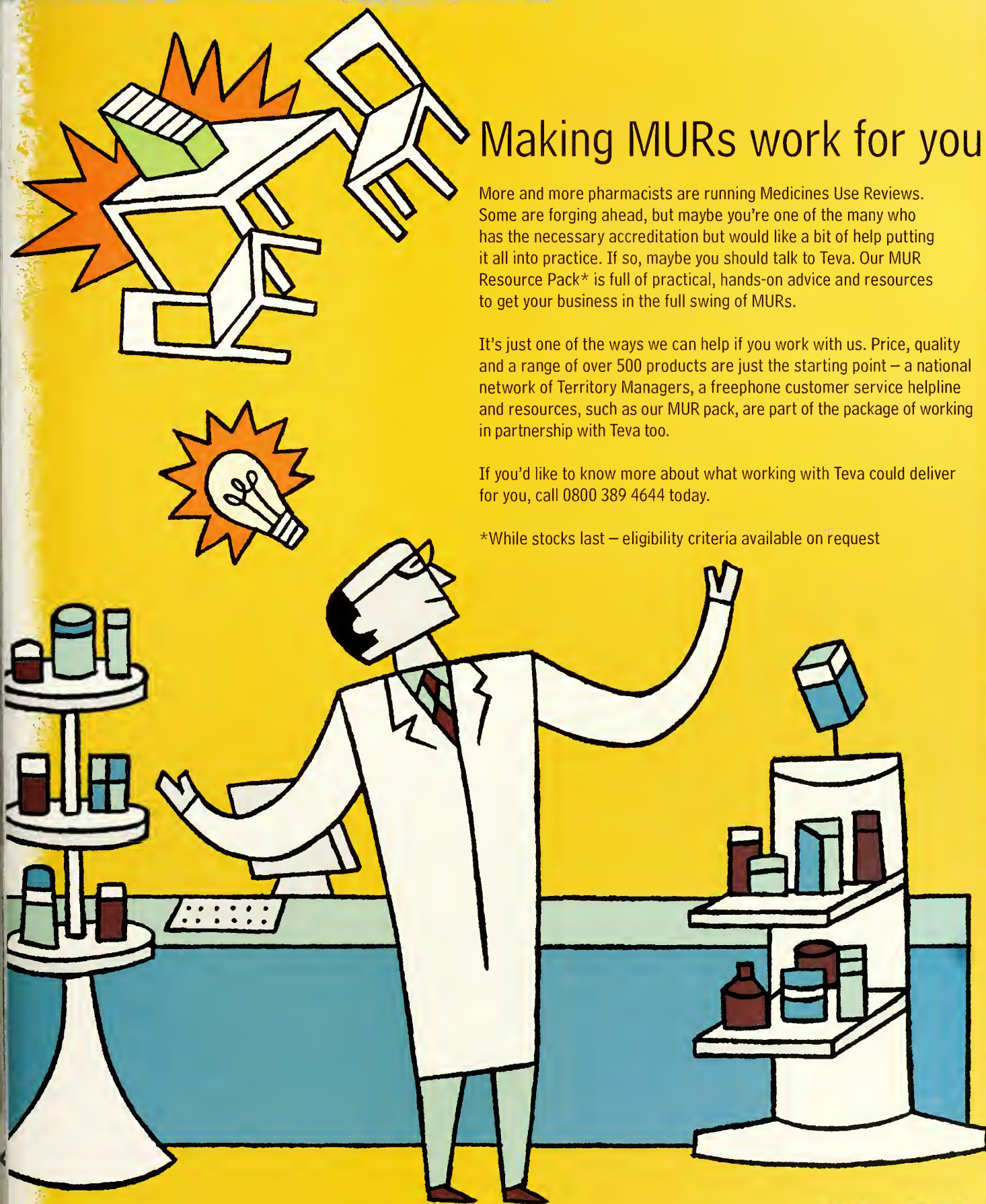
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Case studies: atrial fibrillation

The fourth in this series on cardiovascular disease considers the aims of AF treatment

Key points

- Atrial fibrillation (AF) may be asymptomatic and is often diagnosed opportunistically when patients attend their GP surgery for a blood pressure check.
- Pharmacists who measure BP should be aware that automatic monitors can give unreliable readings in AF, and they should always check the patient's pulse first.
- The first step in treatment is to achieve adequate heart rate control, usually with beta-blockers or rate-limiting calcium-channel blockers.
- To prevent a stroke, patients require thromboprophylaxis with warfarin or antiplatelet drugs such as aspirin.
- Cardioversion is recommended for patients under 65 years old, those with symptoms, and those with structural heart disease such as heart failure. Electrical cardioversion is usually tried first, or pharmacological cardioversion with antiarrhythmic drugs where this is not appropriate.
- Patients should be anticoagulated for at least three weeks before electrical cardioversion. The procedure cannot be performed if warfarin is contraindicated, not tolerated or the target INR cannot be achieved.
- For patients over 65 and those who have coronary heart disease or are unsuitable for cardioversion, rate control therapy is continued, using a beta-blocker or calcium-channel blocker.

Dr Clive Edwards MRPharmS

Atrial fibrillation (AF) is an irregular heart rhythm in which the normal regular electrical impulses from the atrial pacemaker cells of the sino-atrial node are replaced by disorganised rapid impulses. These spread

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Reflect

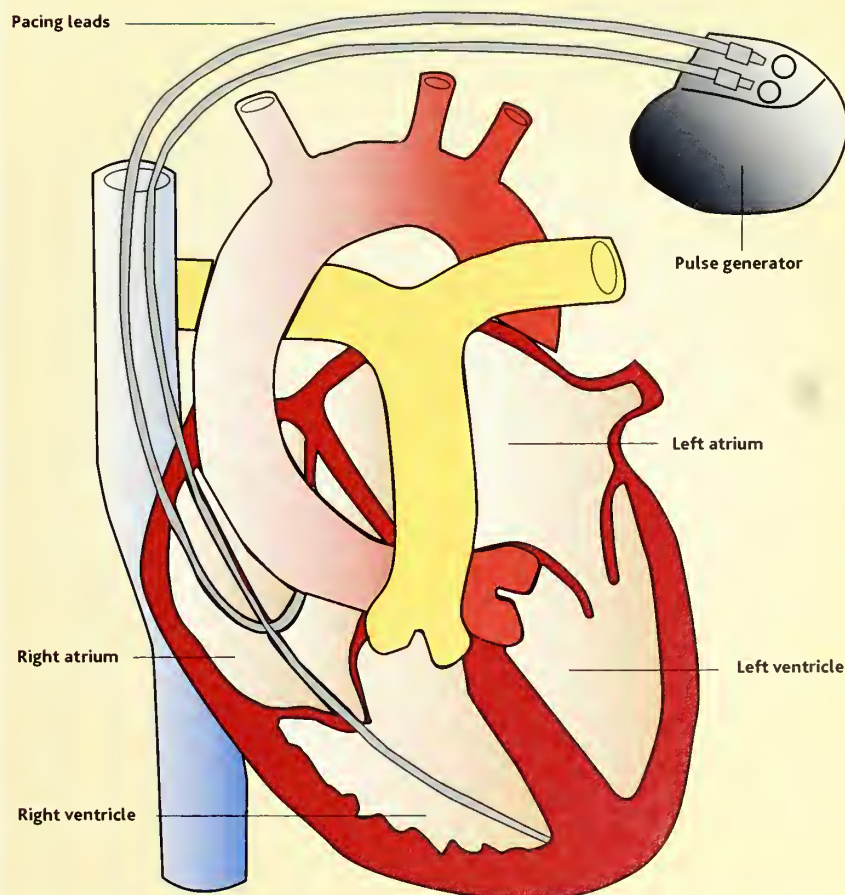
Before you read this article, think about any patients you know with atrial fibrillation. Which drugs do they take, and how do they work? Do any of them use devices to control heart rate? What do you know about the problems associated with measuring blood pressure in patients with AF?

Plan

Search your PMRs for a patient with AF, and talk to them about their condition when they next present a prescription. By reading this article and completing the CPD, you should be better equipped to discuss and advise patients with AF.



This article can help in the following CPD competencies: **G1a, G1d, G1e, C1f, C2e, C3e**. See www.tinyurl.com/194zu



Pacemakers are used to treat AF, but usually only when pharmacological intervention has failed

through the heart and cause the ventricles to contract irregularly. It is the most common chronic cardiac arrhythmia and occurs more with increasing age.

If AF spontaneously reverts to normal (sinus) rhythm within seven days but then recurs, the condition is termed paroxysmal AF. If it persists longer, it is called persistent AF; AF that persists for over a year is referred to as permanent AF.

CASE STUDY 1: Blood pressure monitoring



Mr A is a 60-year-old office worker who has made an appointment for a blood pressure check in his local pharmacy. He feels generally well. His BP is slightly raised at 150/100mmHg, so he returns two weeks later for a second check when the reading is 140/88mmHg. The pharmacist recommends lifestyle changes but reassures Mr A that all appears well. Some weeks later, Mr A presents with a prescription for bendroflumethiazide, atenolol and warfarin. What happened?

Mr A's GP has diagnosed hypertension and AF. The pharmacist should have measured his pulse rate at the wrist for 20 seconds before taking a BP reading. If the pulse was not regular, Mr A should have been referred to his GP.

The reason is that many automated BP monitors are only validated and calibrated for patients in sinus rhythm, and vary in their ability to generate reproducible and reliable readings in AF. Some have been tested and approved in AF, whereas others have not. If the amount of blood leaving the heart is not constant, BP varies from one heartbeat to the next. Thus in AF, where a ventricular arrhythmia may be causing a variation in stroke volume (the amount of blood ejected from the ventricles), BP can vary. This goes some way to explaining Mr A's apparently normal measurement at his second visit.

Clinically, this is important, because hypertension can cause AF. Uncontrolled AF can cause thromboembolism, most commonly a stroke, and concomitant

hypertension can contribute. Thus Mr A was in a vicious circle, which could have had serious consequences if he had not chosen to have another BP check at his GP surgery.

It is important that pharmacists incorporate the above screening procedure when providing a BP monitoring service. Many patients with asymptomatic AF are diagnosed during a routine or opportunistic check.

CASE STUDY 2: Controlling heart rate

Mr A's suspected AF was confirmed by an electrocardiogram (ECG). The GP prescribed atenolol 50mg daily to slow down the heart rate and, after a visit to the cardiology clinic, Mr A was given an appointment for an electrical cardioversion in four weeks' time and a follow up in the outpatients clinic in another four weeks. Warfarin was prescribed.

Mr A's diagnosis was fortuitous, since he had no warning symptoms. Patients often feel the irregular heart beats as palpitations in the chest, angina can occur and heart failure can develop. Patients may suffer dizziness and syncope. It is necessary to regulate tachycardia, not only to make the heart more efficient and prevent complications such as heart failure and coronary heart disease, but also to reduce the risk of a stroke. When the atria do not pump efficiently, blood can pool and coagulate. Clots can escape and travel to the cerebral circulation where they can cause a stroke. The aims of treatment are therefore to regulate the heart rate and prevent thromboembolism.

Mr A's GP initiated atenolol, aiming to reduce his heart rate to fewer than 100 beats per minute. Beta-blockers are the standard first-line treatment but, if contraindicated or not tolerated, a rate-limiting calcium-channel blocker such as diltiazem or verapamil may be used instead. Nowadays, digoxin is only used as monotherapy to treat AF in sedentary patients, but it can be added into a regime of rate-controlling drugs.

The cardiologist has decided that Mr A's heart rhythm should be normalised by electrical cardioversion. Nice gives guidance about which patients should undergo rhythm control using either electrical cardioversion or antiarrhythmic drugs, including those who:

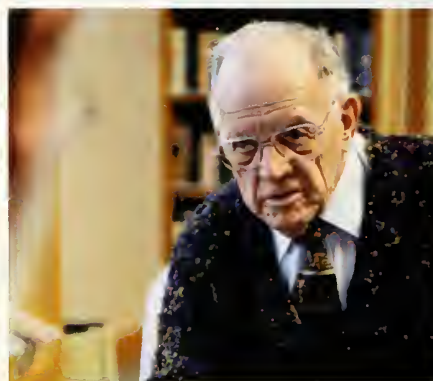
- are younger than 65 years
- are symptomatic
- have heart failure.

Electrical cardioversion is usually the first option because antiarrhythmic drug options such as sotalol or amiodarone have many adverse effects

and require close monitoring. They are reserved for patients who are unsuitable for electrical cardioversion or in whom the procedure has failed to restore sinus rhythm.

Mr A will undergo the procedure in one month's time, because it is necessary to anticoagulate him for at least three weeks prior to the procedure, which itself can generate thromboemboli. The target INR is 2.5 (range two to three). Anticoagulation should also continue for at least one month after cardioversion.

CASE STUDY 3: Patient with heart failure



Mr B is 75 years old and has had permanent AF for several years. He is taking drugs for hypertension and coronary artery disease. His cardiologist recently noticed signs of heart failure and changed his anti-arrhythmic drug from sotalol to amiodarone. His wife presents you with his latest prescription and asks what you know about amiodarone.

Patients who have not responded to beta-blockers and electrical cardioversion will usually be changed to a class 1c agent such as flecainide or propafenone or to sotalol (Nice guidance). Sotalol is a beta-blocker but has other anti-arrhythmic properties. It is used in AF patients with coronary artery disease. Mr B's dose was titrated up to 240mg twice daily, but this was not entirely successful and eventually it was decided to try another agent.

Nice recommends amiodarone for rhythm control in patients with structural heart disease such as heart failure. The drug is effective but has many adverse effects. Mrs B should be reassured that this is the best drug therapy for her husband, but he will need frequent monitoring.

Amiodarone can cause liver dysfunction. It can also cause either hyper- or hypothyroidism, because of the iodine moiety in its molecule. Hence, liver and thyroid function tests, and urea and electrolytes should be measured at six-monthly intervals. ECGs are normally done every six

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Green liquid containing Dextromethorphan Hydrobromide 15mg, Pseudoephedrine Hydrochloride 60mg, Doxylamine Succinate 7.5mg and Paracetamol 600mg in each 30ml dose. Night-time cold medicine. **Adults and children over 12 years:** 30ml at bedtime 10-12 years: 15ml at bedtime. **Caution:** May cause drowsiness. If under the care of your doctor, receiving any prescribed medicines, or pregnant, consult your doctor before use. Contains alcohol. Patients should not take other paracetamol-containing products concurrently. Use with caution in severe renal or hepatic impairment and in those with non-cirrhotic alcoholic liver disease, where hazards of overdose are greater. PL Holder: Procter & Gamble (Health & Beauty Care) Ltd, The Heights, Brooklands, Weybridge, Surrey, KT13 0XP. PL 00129/0029R 180ml £5.99

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Vicks Sinex Decongestant Nasal Spray

Non-pressurised nasal spray containing Oxymetazoline 0.05% w/v, in aqueous solution. Symptomatic relief of congestion of upper respiratory tract due to the common cold or sinusitis. **Adults and children over 6 years:** One to two sprays into each nostril every 6-8 hours unless doctor advises otherwise. **Caution:** Do not use for periods of more than 7 consecutive days. PL Holder: Procter & Gamble (Health & Beauty Care) Ltd, The Heights, Brooklands, Weybridge, Surrey, KT13 0XP. PL 00129/5011R. 20ml £2.99

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Vicks Sinex Decongestant Capsules

Green & White capsules containing Paracetamol 500mg and Phenylephrine Hydrochloride 12.18mg. For relief of symptoms of colds and influenza, including aches and pains, headache, nasal congestion sinus pain and feverishness. **Adults and children over 12 years of age:** 1 capsule to be taken every 4 hours. Maximum of 4 capsules in any 24 hours. **Caution:** Not recommended for children under 12 years. Contains Paracetamol. Patients should not take other paracetamol-containing products concurrently. Immediate medical advice should be sought in the event of an overdose, even if you feel well. Phenylephrine should be used with care in patients with hyperthyroidism, cardiovascular disease, diabetes mellitus, closed angle glaucoma, prostatic enlargement and hypertension. PL Holder: Procter & Gamble (Health & Beauty Care) Ltd, The Heights, Brooklands, Weybridge, Surrey, KT13 0XP. PL 16028/0031. PL Holder: Golphorm Healthcare Ltd, South Yorkshire, S75 3SP. 16ct £3.99

Vicks VapoRub

Ointment containing Menthol 2.75% w/w, Camphor 5.0% w/w, Eucalyptus oil 1.50% w/w and Turpentine oil 5.0% w/w. Symptomatic relief of nasal catarrh and congestion due to colds; sore throat, also cough due to colds. **Adults:** rub liberally on chest and throat and back. Rub in well over the whole area and leave night clothes loose to allow easy inhalation. **Children 6 months and over:** Apply lightly onto chest, throat and back. **Inhalation: Adults only:** Melt two teaspoonfuls in a bowl of very hot, but not boiling, water. Inhale for 10-15 minutes. **Caution:** Do not swallow or place in nostrils. Never reheat the mixture. PL Holder: Procter & Gamble (Health & Beauty Care) Ltd, The Heights, Brooklands, Weybridge, Surrey, KT13 0XP. PL 00129/0130. 50g £2.99

Vicks Inhaler

Nasal stick containing Menthol 125mg, Camphor 50mg and Siberian Pine Needle Oil 10mg. Relief of nasal congestion associated with allergic and infectious upper respiratory tract disorders. Insert into nostril, holding the other nostril closed. Inhale deeply. Use as frequently as necessary. **Caution:** Not recommended for children under 6 years. PL Holder: Procter & Gamble (Health & Beauty Care) Ltd, The Heights, Brooklands, Weybridge, Surrey, KT13 0XP. PL 00129/5009R. One inhaler £2.29



people not symptoms

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months at first, then annually to check the heart rhythm.

Ophthalmological examination is recommended annually but eye problems are rarely encountered. The most common is corneal microdeposits but these are benign. There is insufficient evidence supporting a link with optical neuropathy. Any changes in vision should be reported immediately, but otherwise eye check-ups are not routinely performed.

Amiodarone can cause lung problems and, if any breathing difficulties arise, lung function tests and chest x-rays should be done. The drug can also increase plasma concentrations of other cardiovascular drugs such as warfarin, digoxin and statins. For these reasons, amiodarone is often used as a last resort when other treatments have proved ineffective. Patients are prepared to tolerate the adverse effects because, for many with serious heart problems,

it is the only thing that is keeping them alive.

Non-pharmacological means of treating AF are available, when drug measures are unsuccessful. These include the use of atrial defibrillators, pacemakers and procedures to destroy the abnormal electrical pathways by radiofrequency ablation.

CASE STUDY 4: Patient with a previous stroke

Mr C is a 75-year-old who had a stroke several years ago. This led to him becoming increasingly confused. He lives alone but his daughter visits daily and gives him good support. He has recently been diagnosed with paroxysmal AF. He is on nifedipine and lisinopril for hypertension, and has taken aspirin since his stroke.

What form will his drug treatment take?

Mr C could be started on a beta-blocker such as atenolol for rate control, but in view of his confusion and the fact that he is taking several drugs already, an alternative could be to change his nifedipine to a rate-limiting calcium-channel blocker. This will have a dual effect as an antihypertensive and a rate control agent.

Digoxin could be added if further rate control is necessary. He does not have heart failure and Nice recommends continuing rate-controlling drugs. If these fail, a pharmacological cardioversion using antiarrhythmic drugs could be tried. The decision whether to anticoagulate with warfarin depends on any contraindications. Mr C is 75 and has had an ischaemic stroke so is at high risk of a recurrence. He would normally be a candidate for long-term thromboprophylaxis with warfarin, but in view of compliance, aspirin may be more practical. This is a joint decision between the doctor and the patient or his carer, based on the risk-benefit ratio. If warfarin is contraindicated, or the target INR cannot be achieved, this would rule out an electrical cardioversion at a future date.

Clive Edwards, BPharm, PhD, MRPharmS, is a former lecturer in clinical pharmacy at the University of Newcastle and PCT adviser.

Go to www.chemistanddruggist.co.uk for a further reading list.

Continuing Professional Development



Act

- Read more about AF. The British National Formulary section 2.3.1 (Management of arrhythmias) is a good starting point, but also try www.americanheart.org/presenter.jhtml?identifier=4451. The BNF reference will also help you find out more about the adverse effects of antiarrhythmia drugs.
- Which of the BP monitors stocked in your pharmacy take AF into account? A trial of some US BP monitors can be read at <http://tinyurl.com/285hzn>.
- Do you have any patients with pacemakers? Why do these patients have them? Do they need to worry about an interaction with other electrical devices, such as TENS machines?
- Think back to patients you have seen who have complained of heart palpitations. What conditions caused the symptom?
- Check your PMRs for patients taking digoxin. Is it often used as monotherapy? If not, which other drugs are prescribed?

Evaluate

- Do you now feel you know more about AF, and the problems associated with interpreting BP results? Will this alter the way you conduct BP monitoring?
- A newly diagnosed AF patient tells you he has been told he needs electrical cardioversion. Can you explain his condition and treatment?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the December 1 issue, which will cover this week's CPP-accredited module, together with those in the November 3 and 17 issues.

These will cover:

- Lung cancer early signs (1421)
- CVD case studies 4 (1422)
- Insulin treatment (1423)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

Chemist + Druggist
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GENUS PHARMACEUTICALS

For a free weekly email alert on C+D's Pharmacy Update series, please register at:

www.chemistanddruggist.co.uk/register



HPV vaccine works for older women

Asha Fowells

The quadrivalent human papillomavirus (HPV) vaccine appears as effective in older women as it is in teens.

Nearly 4,000 women aged 24 to 45 took part in a randomised double-blind study comparing Gardasil – the vaccine effective against HPV types 6, 11, 16 and 18 – to placebo. Efficacy against persistent infection, pre-cancerous cervical and vaginal lesions, and external lesions was 91 per cent for those on the active arm of the trial.

The findings were presented at the 24th International Papillomavirus Conference in China. Gardasil maker Sanofi Pasteur MSD claims this is the first time a cervical cancer vaccine has been shown to prevent HPV-related gynaecological disease in older women, and says that this patient group could benefit from vaccination.

Last month it was announced the HPV vaccine would be added to routine immunisations for girls aged 12 and 13 years from next autumn, with a catch-up programme to follow for girls aged up to 18.

Clinical Matters

Inhaled budesonide safe

Babies of mothers who use a maintenance treatment of inhaled budesonide do not present measurable quantities of the treatment in breast milk. The data supports the use of the drug during breastfeeding, say the authors.

J Allergy Clin Immunol 2007; 120: 798-802

Zoledronic cuts risk

Annual treatment with intravenous zoledronic acid following hip fracture reduces the risk of further fractures and improves survival, according to a study published in the New England Journal of Medicine.

NEJM 2007; 357: 1799-809

MRSA fatalities are not clear cut

The majority of people who die following MRSA infection had short life expectancies because of underlying conditions, new data has suggested.

A qualitative study of over 50 patients who had the superbug when they died

found just over half could be attributed to methicillin-resistant *Staphylococcus aureus*. The most frequent source of infection was invasive devices, such as intravenous drips and catheters.

The Health Protection Agency, which

conducted the study alongside the Office for National Statistics, said that although the results could not be generalised to all trusts, they did illustrate "shortcomings in the management of MRSA infection".

<http://tinyurl.com/25mj7z>

A Practical Approach

Methadone dilemma



methadone on private scripts."

"I see. Did you ask him about it?"

"I did, but he told me in no uncertain terms to mind my own business. He said he wasn't doing anything illegal, and I suppose he's right."

"What do you think I ought to do about it?" David asks. "I can't imagine the drug dependency clinic would approve if they knew. And I wonder if the private doctor knows he's getting regular NHS supplies? Should I contact either or both of them, do you think? Have you come across this sort of thing before?"

"No I haven't. And you don't know what you are and aren't entitled to do in these days of human rights, confidentiality and data protection," replies the locum.

Questions

1. What are David's rights and responsibilities in this situation?
2. What should David do?



This article can help in the following CPD competencies: **G1e, G1h, G7d, C3g**. See www.tinyurl.com/194zu

Brenda, Update Pharmacy's dispensing technician, puts through a telephone call for pharmacist David Spencer.

"Hello, Mr Spencer," says the voice at the other end of the line. "I thought I'd follow up the note I left yesterday when I covered for you."

"Ah yes, thank you. You said you'd come across one of our methadone instalment patients in another pharmacy."

"That's right. He comes in to another pharmacy, I locum at regularly for

inspector or the police. Informing both prescribers and the RPSGB could be acting in the public interest in David feels he is not telling the truth, David the patient refuses to discuss the matter or other is prescribing methadone for him. If himself to if he has not told both that the explain the possible dangers he is exposing prescribers are aware of the situation, and with the patient to find out if both 2. David should first discuss the matter. David's ethical obligations to the patient. confidentiality both under the law and and balance it against the patient's right to do, David has to weigh up these factors, aware of the first supply. In deciding what where the prescriber has not been made unlawful if it is made against a prescription Also, the possession of the second supply is stealing to pay for the private supplies. some of the methadone he has obtained, or be at risk if the patient is illicitly selling on situation. The interests of the public may both prescribers being aware of the is taking additional methadone without patient may be risking harm to himself if he individual patient and the public. The and act in the best interests of the 1. David's responsibilities are to consider

Answers

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Wockhardt UK Limited, Ash Road North, Wrexham Industrial Estate, Wrexham LL13 9UF, UK. Tel: 0800 262 570

Report Adverse Events to licence holder on 0800 262 570. Information on AE reporting www.yellowcard.gov.uk

Nrt01/07/c August 2007

Electronic CD register debuts

A new electronic controlled drug register from Denward Manufacturing was demonstrated at last month's Pharmacy Show. The register includes a complete controlled drug database and complies with all relevant legislation, says the company.

The flexible system keeps a log every time the user clicks on OK, with everything ordered according to when each entry is made. Different users – including inspectors – can log on with individual passwords, with access and functions tailored accordingly.

The electronic register can take details of stock received, transfers, automatic balancing and stocktaking, says the company. The system is standalone and not linked to a PMR system. It costs £300 for the software with a further £300 payable annually for support. A pump for methadone



dispensing will be added within the next three months, says Denward.

A free 28-day trial disk is available by phoning the number below.

Product info:

Denward Manufacturing
Tel: 01245 492986
www.pharmacy-equipment.co.uk

Meet Eumocream

The granting of a GSL licence to GSK has triggered the relaunch of Eumobase, with the new name Eumocream. Made with the same 25 per cent w/w glycol formulation, Eumocream is deemed a more consumer friendly and recognisable brand name.

The GSL licence allows more compelling claims to be made on pack, says GSK. Eumocream is described as a non-steroidal, hydrating treatment cream formulated to moisturise dry, sensitive, itchy skin including skin prone to eczema and dermatitis.



Product info:

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Topical support

Recent newcomer to the skincare fixture, Atopiclair, is currently being promoted to dermatologists and GPs.

The non-steroidal cream is suitable for the treatment of mild to moderate atopic dermatitis. It calms itching and burning, replaces skin lipids and hydrates the skin while supporting normal skin barrier function, says manufacturer Ashbourne.

Clinical studies have shown the

product brings significant improvements in six key dermatological outcomes. Further details can be found on the brand's website.

Prices and Pip codes:

£6.20/40ml, 327-4214;
£12.40/100ml, 327-4222
Ashbourne Pharmaceuticals
Tel: 01604 883100
www.atopclair.co.uk

Keep Active with Beechams' latest

Beechams Active Cold Relief is the latest addition to the winter remedies fixture from GlaxoSmithKline.

Containing paracetamol, caffeine and phenylephrine HCl, the GSL caplets are said to provide effective relief from the major cold and flu symptoms.

The product is designed for people who need to get on despite having a cold, says GSK. Caplets are packaged in a crush-resistant 'compact' wallet to offer protection when carried in a pocket or handbag. With rounded

edges, the pack clicks open, revealing the product and patient information.



Price: £3.49/14

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637



Products advertised on TV next week

Ambi Pur: All areas

Bassetts' Soft&Chewy Omega 3 Extra: GMTV, five, Sat
Bimuno: Meridan

Bonjela: Sat, C4, five

Covonia: GMTV, Sat, five

Gaviscon Liquid and Handy Pack: All areas

Lyclear SprayAway & Repellent: GMTV, Sat

Optrex: All areas

Rennie Dual Action: All areas

Seven Seas' JointCare & CLO: All areas

WindSetlers and Setlers Heartburn: GMTV, five

PharmaSite for next week: Ibuleve – windows, Ibuleve – in-store, Ibuleve – dispensary

Pharmacy channel: Murine, Senokot

WANTED

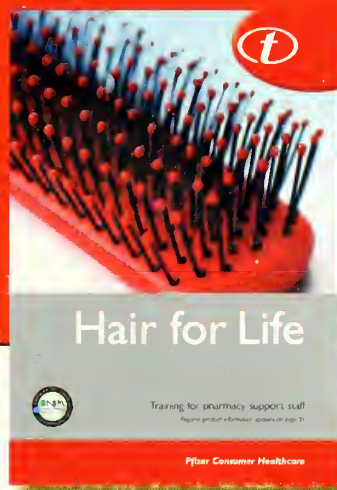
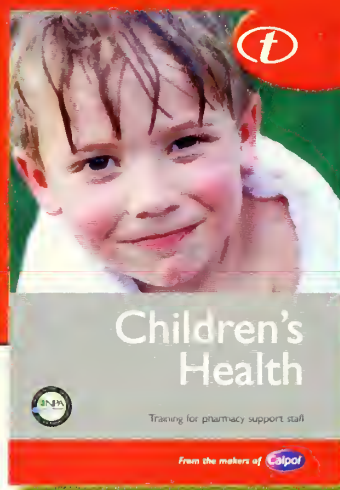
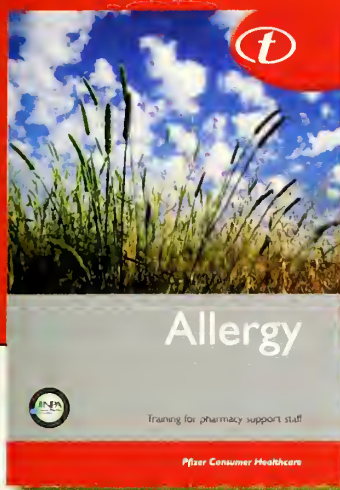
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Training for Pharmacy Support Staff



Makeover for Murine

Eyecare product Murine is sporting a new look, name and claims.

Designed to highlight the product's dual action, it becomes 'Murine irritation and redness relief eye drops' with the on-pack claim that it 'clears minor irritation and redness in eyes'.

It claims to be fast-acting and long-lasting. The formulation, price and pack

size are unchanged.

Point of sale materials highlighting the new look are available from Ceuta Healthcare, including a shelf talker to be distributed in next week's C+D.

Product info:

Ceuta Healthcare
Tel: 01202 780558



Products in brief

Clarification

In the October 27 issue of C+D (p28 'Biodose MDS handles liquids') it was stated that the Nomad MDS system belongs to Protomed. This is not the case. The founder and managing director of Protomed is Norman Niven, former owner of Surgichem Ltd and the person who developed the Nomad MDS system. Protomed and Biodose are in no way affiliated or connected to Surgichem.

Listen to Lockets

Listeners to Magic FM could be going on a £1,500 shopping spree courtesy of Lockets. The medicated confectionery brand is sponsoring the station's morning weather bulletins, aiming to reach women aged 25 to 44. Mars, tel: 01753 550055.

Footy supporter

Wash & Go shampoo has teamed up with footballer John Barnes and the Link Ethiopia good cause for a charity campaign. Procter & Gamble, tel: 01932 896000.

Aquafresh starts them young

Mums of young children are the target for marketing activity for GSK's Aquafresh Children's range.

Online, national press, Bounty Bag sampling and children's TV activity revolves around the 'learn, brush, grow with Aquafresh' concept, aiming to help parents establish a good oralcare regime for their children.

A 'Mother & Child/Baby' area is new on the brand's website where, for example, toothbrushing charts and educational messages are on offer. The first 100,000 mums to

register will get a free story book.

Advertorials in the parenting press will run from November until January with an educational slant.

A 90-second animation has been developed in conjunction with the Cartoon Network TV channel to be shown daily for 18 months.

Product info:

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.aquafresh.co.uk



CRISIS



Chlorhexidine digluconate

Where Corsodyl stops.....

Product Information. Corsodyl Mint Mouthwash

Presentation: A colourless solution containing 0.2% w/v chlorhexidine digluconate. **Indications:** Plaque inhibition, gingivitis, maintenance of oral hygiene, post periodontal surgery or treatment, aphthous

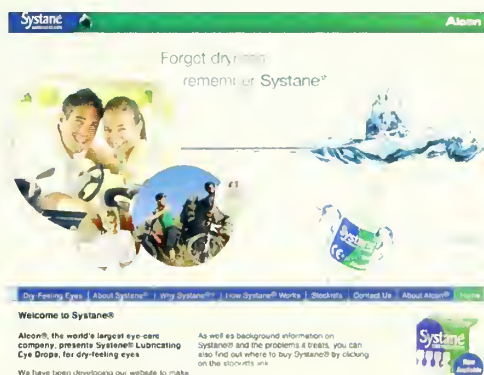
ulceration; oral candida. **Dosage & Administration:** Rinse with 10ml for 1 minute twice daily or pre-surgery. Soak dentures for 15 minutes twice daily. Treatment length: gingivitis 1 month; ulcers, oral candida 48 hours after clinical resolution. **Contraindications:** Chlorhexidine hypersensitivity. **Precautions:** Keep out of eyes, separate use from conventional dentifrices (e.g. rinse mouth

Systane's web update

The website for Alcon's Systane lubricating eye drops has been relaunched.

The new-look site is designed to be more visually appealing, user-friendly and informative. Detailed information is included on the problem of dry-feeling eyes and how Systane can help.

A visual demonstration



shows viewers how Systane works.

There's a stockists section and further information about the company is displayed under 'About Alcon'.

Product info:

Alcon Laboratories
Tel: 01442 341234
www.systane.co.uk

Products in brief

Switch ahead?

Reclassification from POM to P may be on the horizon for benign prostatic hyperplasia treatments. The commission on human medicines at the MHRA discussed the move at its July meeting.

Parents' choice

Metanium nappy rash ointment has been named winner of the Baby Skincare category at the 2007-08 Practical Parenting awards. Speaking at the event last month, brand manager Katie Miller said: "Metanium has been tried and trusted by parents and health professionals for over 50 years now and this award proves that it has the staying power to stand the test of time."

Ransom Consumer Healthcare
Tel: 01274 526360.

Festive foray

Santa and a reindeer feature on two new soothers from MAM. Further designs in the MAM Christmas range include penguins and angels. MAM (UK) Ltd
Tel: 020 8943 8880.

Purepotions for skin salvation

Purepotions is a range of skincare products new to the pharmacy sector.

Made using only natural ingredients, skin salvation salve and bath oil are suitable for people with eczema, psoriasis and other dry, itchy skin conditions.

Skin salvation contains hemp, olive and safflower oils, beeswax and tinctures of nettle, chickweed, calendula and chamomile.

The salve has a shelf life of 30

months, the oil 18 months.

A baby range is also available and point of sale materials can be requested.

Price: salve £4/15ml, £7/30ml, £10.50/60ml, £16/120ml;
oil £7/100ml
Purepotions
Tel: 01273 623123
Email: info@purepotions.co.uk
www.purepotions.co.uk

READER OFFER

For the next four weeks, C+D readers can order a point of sale display pack for £56.80, a 20 per cent discount on the usual wholesale price. The contents comprise two 120ml and six 60ml salves and three bath oils with a total retail value of £116. Call Purepotions and quote 'C+D reader offer'.

MANAGEMENT

...Corsodyl Daily Defence carries on



With low strength chlorhexidine digluconate and fluoride it's quite a mouthful

between applications) **Pregnancy & Lactation:** No special precautions. **Side effects:** Superficial discolouration of tongue, teeth and tooth-coloured restorations, usually reversible; transient taste disturbances and burning sensation of tongue on initial use; oral desquamation; parotid swelling; irritative skin reactions; extremely rare, generalised allergic reactions. **Legal category:**

GSL. **Product Licence Number and Basic NHS Cost:** PL 00079/0312 300ml £1.93 600ml £3.85. **Licence Holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Date of preparation:** May 2006. **CORSODYL** is a registered trade mark of the GlaxoSmithKline group of companies.

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www.cymex.co.uk

Indication: White cream containing 1.0% w/w urea BP, 0.5% w/w Cetrimide BP, 9.0% w/w Dimeticone BPC and calcium for the application to cold sores and cracked lips. Dosage: Apply sparingly every hour. Contra-indications: External use only. If symptoms persist consult a doctor. Interactions: None known. Pregnancy and lactation: Caution. Unfavourable effects: None known. Legal category: GSL. MA number: 0083/0026. MA Holder: E.C. De Witt. Price: £7.47 for a tube of 6. Pack size: 5g tube. Date of preparation: 28 September 2007. 2007 OTC-0235.


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- CONTROLS INFECTION



Under the white coat

- The best days as a pharmacist are those when people come back to say they took your advice and it really worked. You feel like you are doing something worthwhile, not just dishing out pills.
- When I was growing up I wanted to be a journalist but my dad said I couldn't because it wasn't a profession, so that threw me off.
- If I was in charge of pharmacy I would like people to be judged not on how many items they have dispensed, I would make it how many lives they have changed or touched, and how much they have helped those people.



Church service

Jennifer Reid, of Fairoak Pharmacy in Streatham, London, has taken a lifestyle assessment service outside the pharmacy, delivering it to her local church community

Initially, I offered a lifestyle assessment service in the pharmacy. The test costs £30 and involves measuring a patient's weight, height and waist circumference, then checking their blood pressure and cholesterol levels, and testing for diabetes. Once the tests are completed, the results are inputted into a computer software programme which calculates their coronary risk. Essentially, it enables you to determine whether the patient has a risk of developing heart disease within the next 10 years, and how high that risk is.

AAH helped me to set up the scheme. We were trying to target people who would not normally visit their GP about these issues, and encourage them to be aware of their health. AAH sent someone to the pharmacy to train me in doing the assessments, and although that took the best part of a day, they really made sure I was comfortable in what I was doing.

Out of hours

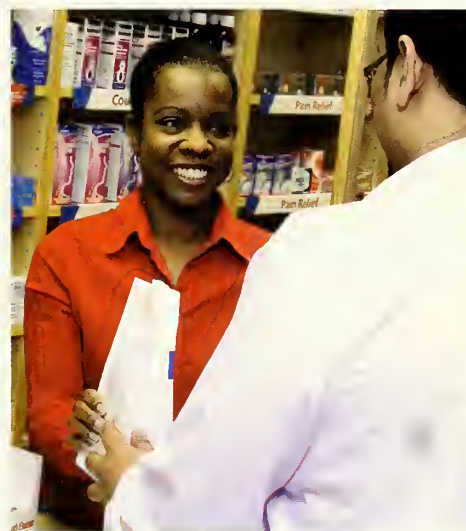
- There is a hotel that I go to sometimes near Windsor, with a spa, so I'll have some massages, and go in the sauna or jacuzzi to completely unwind.
- My guiltiest pleasures are Green & Black's chocolate and ice cream.
- I raise money for a heart foundation in Jamaica. The foundation equips a van that goes around the island giving health checks to people who can't afford it and it pays for a teacher who goes into schools and teaches the children about healthy living.

I started offering the service in the autumn of 2006, but it took a bit of time to raise awareness among customers. It did start to pick up in the pharmacy but I thought it would be a good idea to take it out into the community. Lots of people don't come into the pharmacy, but could benefit from a check up.

So I approached my local church and asked if they would like me to offer the assessments after their services. They agreed, so the next step was making an advert. The church often runs adverts on a big screen, and there is a man who works there and can make the films for you. I told him exactly what I wanted from the advert and he made it. It looked great, it was all about somebody running and wanting to get in touch with being healthy and it was like watching TV.

Lots of people said they wanted to have the checks done and signed up, so we ran one session a month at the church for four months, beginning last January. It was straightforward to set up because it got such a good response when the advert went out, the difficult thing was lugging all the equipment there on a Sunday and trying to set it all up after the service.

I think taking this out to the community is important. A lot of people are really busy and find it difficult to come out to the pharmacy, so it's a good thing if you can provide these services in a place where they are going to be, even if it is a pub. Many people who wanted to do the tests were people who don't get to see their GP very often, they just wanted to see what their health state was. We picked up on quite a lot of things with them, to do with eating styles particularly. The assessments themselves are great too,



because you get to know your customers on a different level rather than just dishing out prescriptions. It is quite time consuming, but I have one member of staff who can do all the tests so I can take over and talk to the patient once she has done that, which makes it easier.

The service has been very popular; every week somebody asks me at church when I am going to do it again, so I will run more sessions and then look to take it out to other churches in the area.



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Balance of payments

As the DH opens yet another consultation on the supply of stoma and incontinence appliances, **Emma Wilkinson** looks at some of the concerns over the new arrangements and the implications for pharmacists

It's been three years and four consultations since the Department of Health first set out to alter the arrangements for provision of stoma and incontinence appliances – arrangements which had been in place unchecked for two decades and which most agreed were not working.

Under current rules, pharmacists often have to dispense at a loss, offsetting costs with other NHS work – a situation PSNC describes as unacceptable for what is effectively a stand-alone service – or choose not to dispense at all.

Different reimbursement arrangements for pharmacy and appliance contractors mean there is an imbalance in payments. And the DH believes the NHS is not benefiting from apparent reductions in underlying manufacturing costs and wants to cut millions from the current spend.

The latest round of revisions is out for

consultation until December 28. So have pharmacists and the DH finally reached common ground? It would appear not, at least according to PSNC, which warns that the proposals, which initially had been pegged for implementation in July this year, will reduce patient access by increasing the number of times pharmacists are faced with supplying an appliance at a loss – exacerbating an already difficult situation. PSNC also says the costing information provided so far was "wholly unrealistic".

The National Pharmacy Association is also highly critical, saying it was "totally unacceptable" that the government has not addressed the issue of nurse posts being sponsored by appliance manufacturers. It was equally unhappy with the cost calculations, particularly those relating to specialist nurse visits and the delivery of appliances.

The latest proposal will increase the times pharmacists are faced with supplying an appliance at a loss



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for chesty coughs (200mg Guaifenesin)

Lemsip Max All In One Lemon Essential Information

Active ingredients: Paracetamol 1000mg, Phenylephrine hydrochloride 12.2mg and Guaifenesin 200mg per sachet. **Indications:** For relief of the symptoms of colds and influenza, including the relief of aches, pains, sore throat, headache, nasal congestion, lowering of temperature and chesty cough. **Dosage Instructions:** Oral administration after dissolution in water. Adults and children over 12: One sachet dissolved by stirring. Dose may be repeated every 4-6 hours. No more than 4 doses should be taken in 24hrs. Not to be given to children under 12 without medical advice. **Contraindications:** Hypersensitivity to any of the ingredients. Severe coronary heart disease. Hypertension. **Precautions:** To be used with caution by patients with severe hepatic or renal dysfunction, Raynaud's Phenomenon, diabetes. Do not take with any other paracetamol-containing products. The product contains paracetamol and the stated dose must not be exceeded. Keep out of the reach of children. If symptoms persist, the patient should consult a doctor. Patients who are pregnant or are being prescribed medicine must seek a doctor's advice before taking this product. Phenylephrine may adversely interact with other sympathomimetics, vasodilators and beta-blockers. Drugs which induce hepatic microsomal enzymes, such as alcohol, barbiturates MAOI drugs and tricyclic antidepressants, may increase the hepatotoxicity of paracetamol, particularly after overdosage. Not recommended for patients currently receiving or within two weeks of stopping therapy with MAOIs. The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine. Guaifenesin may increase the rate of absorption of paracetamol. Guaifenesin may interfere with the diagnostic measurements of urinary 5-hydroxyindoleacetic acid or vanillylmandelic acid. The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with increased risk of bleeding: occasional doses have no significant effect. Contains aspartame. **Side-Effects:** Adverse effects of paracetamol are rare, but hypersensitivity including skin rash may occur. There have been a few reports of blood dyscrasias including thrombocytopenia and agranulocytosis, but these were not necessarily causally related to paracetamol. Phenylephrine hydrochloride: High blood pressure with headache and vomiting, probably only in overdosage. Rarely palpitations. Also, rare reports of allergic reactions. **Legal Classification:** GSL. **Licence Holder:** Reckitt Benckiser Healthcare (UK) Ltd, Dansom Lane, Hull, HU8 7DS. **Licence Number:** PL 00063/0168 **Price:** £4.99 for 10s. **Date of preparation:** May 2007.

Information about adverse event reporting can be found at www.yellowcard.gov.uk
Adverse events should also be reported to Medical Services, Reckitt Benckiser Healthcare (UK) Ltd. Telephone 0500 455456.

¹ Compared to the leading All In One ² AC Nielsen unit sales 52 w/e 8th September 2007

Market pressure

PSNC says these changes do not alter many of the main concerns it has with the proposals – specifically that there is little protection in ensuring uninterrupted supply of a variety of products for particularly vulnerable patients who have to trust in their regular product.

Switching between brands for financial reasons is not appropriate and can have an adverse impact on patient care, it warns.

Lindsay McClure, head of information services at PSNC, says: "As the proposals stand, there is real potential for the market to be manipulated by vertically integrated appliance contractors."

"To protect patient access to these products, we believe the DH should have the power to remove appliances from the Drug Tariff if the costs to pharmacies in obtaining an appliance exceed the reimbursement price."

She also maintains that the Department's costing information remains "unrealistic" and does not offer any incentive to pharmacy contractors to provide the service.

Both the Competition Commission and the Office of Fair Trading have previously stated that the remuneration structure for appliance contractors and community pharmacies has made it financially advantageous for a manufacturer to supply products through their own vertically integrated appliance contractor, leading to distortion in the market.

Ms McClure adds: "The Department's proposals do not address the current inequity in funding. Pharmacy contractors are subject to

discount deduction from their reimbursement payments, appliance contractors are not.

"We believe that stoma and incontinence appliances should be removed from the discount deduction arrangements," she says.

PSNC had also raised concerns about what would happen if "agency agreements" between pharmacists and appliance contractors were discontinued. But it seems pharmacy contractors will still have the option of working

together with appliance contractors in a commercial manner, it says.

PSNC is also worried about the potential for nurses employed by appliance contractors to further influence demand for a particular product as well as the choice of dispenser.

Ultimately, patient groups using stoma and incontinence products have complex needs and are particularly vulnerable and we need to make sure we get the arrangements right, says PSNC.

Proposed changes currently under consultation



- Provision of home delivery and complementary supplies to extend to catheters and incontinence items, not just stoma appliances.



- Additional dispensing fee should be £3.23 rather than the £2.60 previously proposed. Specialist nurse home visits should be extended to catheter and incontinence patients, not just stoma patients, at £40 per visit.



- Customisation of stoma appliances should attract a £3 fee per item but for no more than 25,000 items a month.



- The infrastructure payment for appliance contractors has been altered from six to 10 levels.



- The classification list of 5,000 stoma and incontinence products has been revised.



- Respondents have been offered two options for cutting Drug Tariff prices – cutting on the basis of a previously proposed formula, subject to a 35 per cent cap, or cutting all prices by 12 per cent.



- It is estimated that these price cuts, whichever option is chosen, will lead to savings of £25 million a year on the current annual spend of £200m. This compares with a previously sought £27m saving.



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*Source: NICE Implementation update report: Statins

**Based on people taking 20mg/day

***Roulock et al (2004) Archives of Pharmacology 51: 352-357

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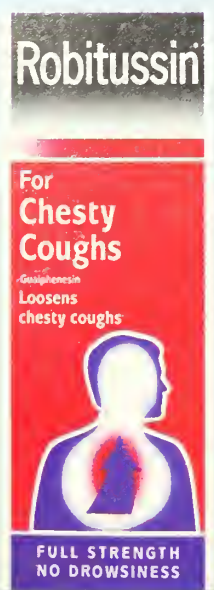


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ROBITUSSIN* CHESTY COUGH MEDICINE. Presentation: Cherry flavour liquid for oral administration. Each 5 ml contains Guaiphenesin Ph Eur 100 mg. Indications: Expectorant for the treatment of coughs. Dosage: Adults, the elderly and children over 12 years: 10 ml four times daily. Children 6-12 years: 5 ml four times daily. 1-6 years: 2.5 ml four times daily. Under 1 year: Not recommended. Contraindications: Hypersensitivity to any of the ingredients. Interactions: None stated. Special warnings and precautions: None stated. Side effects: None stated. Effects on ability to drive and use machines: None stated. Incompatibilities: None stated. Use during pregnancy and lactation: Evidence of safety of guaiphenesin products in pregnancy and lactation is at present incomplete. However, wide usage for many years has shown no apparent ill consequences. Pharmaceutical precautions: No special precautions. Shelf life: 3 years. Legal category: GSL. Package quantities and prices RRP: Amber plastic bottles of 100 ml £3.59. Marketing authorisation no: PL 00165/0097. Marketing authorisation holder: Whitehall Laboratories Limited trading as Wyeth Consumer Healthcare, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH. Date of preparation: July 2005.

ROBITUSSIN* CHESTY COUGH WITH CONGESTION MEDICINE. Presentation: Cherry flavour liquid for oral administration. Each 5 ml contains Guaiphenesin Ph Eur 100 mg, Pseudoephedrine Hydrochloride BP 30 mg. Indications: Nasal decongestant and expectorant for the symptomatic relief of respiratory tract disorders. Dosage: Adults, the elderly and children over 12 years: 10 ml up to 4 times daily. Children 6-12 years: 5 ml up to four times daily. 2-6 years: 2.5 ml up to four times daily. Under 2 years: Not recommended. Contraindications: Hypersensitivity to any of the ingredients. Patients with ischaemic heart disease, thyrotoxicosis, glaucoma, diabetes, enlargement of the prostate or urinary retention. Patients currently receiving, or who have within the last two weeks received, monoamine oxidase inhibitors. Patients receiving tricyclic antidepressants. Patients receiving other sympathomimetic drugs. Interactions: An increased risk of cardiac arrhythmias may occur if sympathomimetics (such as pseudoephedrine hydrochloride) are given to patients receiving cardiac glycosides. Sympathomimetics may also increase blood pressure and therefore special care is advisable in patients receiving antihypertensive therapy. Special warnings and precautions: Not to be taken by patients receiving either cardiac glycosides or antihypertensive agents, except on advice from a doctor. Side effects: May act as a cerebral stimulant in children and occasionally adults. Effects on ability to drive and use machines: None stated. Incompatibilities: None stated. Use during pregnancy and lactation: Should not be used during pregnancy unless directed by a physician. Pharmaceutical precautions: No special precautions. Shelf life: 3 years. Legal category: P. Package quantities and prices RRP: Amber plastic bottles of 100 ml £3.59. Marketing authorisation no: PL 00165/0098. Marketing authorisation holder: Whitehall Laboratories Limited trading as Wyeth Consumer Healthcare, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH. Date of preparation: July 2005.

ROBITUSSIN* DRY COUGH MEDICINE. Presentation: Cherry flavour liquid for oral administration. Each 5 ml contains Dextromethorphan Hydrobromide Ph Eur 7.5 mg. Indications: For the relief of persistent dry irritant coughs. Dosage: Adults, the elderly and children over 12 years: 10 ml three or four times daily. Children 6-12 years: 5 ml three or four times daily. Under 6 years: Not recommended. Contraindications: Hypersensitivity to any of the ingredients. Interactions: Use with caution in patients with hepatic dysfunction. Side effects: Rarely causes dizziness and GI upset. Effects on ability to drive and use machines: None stated. Incompatibilities: None stated. Use during pregnancy and lactation: Not recommended. Pharmaceutical precautions: No special precautions. Shelf life: 3 years. Legal category: P. Package quantities and prices RRP: Amber plastic bottles of 100 ml £3.59. Marketing authorisation no: PL 00165/0100. Marketing authorisation holder: Whitehall Laboratories Limited trading as Wyeth Consumer Healthcare, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH. Date of preparation: July 2005.

*Trade Mark



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From: **Hawkeye on the web**
 Date: **Sat 10.11.07**
 Subject: **Food for thought**



It's never easy to justify a doughnut. But after battling round the supermarket for the week's provisions I reckon I've earned it. Briefly I tussle with my conscience but the sugar-coated reward is dispatched inevitably into the trolley with a minor pang of guilt.

'Beep!' my trolley protests, flashing disapproving red lights at my unhealthy decision. With a sense of shame I grudgingly put them back.

Or at least that might be the case in the future. For now, the 'intelligent' trolley is only at the trial stage and the doughnuts have made it to the checkout. If it catches on, however, shoppers across the UK could soon be guided around their local Tesco or Sainsbury's by machine, encouraged to pick up the healthier options and admonished for choosing anything high in fat, salt or sugar (tinyurl.com/28ro5v).

The system works by customers loading their dietary requirements and personal medical information, such as allergies and family history, onto loyalty cards that are fed into the trolley. This sounds rather extreme but with obesity given the same billing as global warming (tinyurl.com/27ddeo), you could argue extreme measures are called for.

Alternatively it seems more sensible that healthy eating advice comes not from a trolley but from a pharmacy (tinyurl.com/3afat6).

Pharmacists are ideally placed to explain the benefits of a good diet to patients that are overweight and prone to developing conditions such as heart disease and diabetes.

By the same token they are in a strong position to educate, refer and support patients with conditions that require particular dietary requirements – something the House of Lords' science and technology committee found is severely lacking in relation to allergy sufferers (tinyurl.com/29txgh).

The challenge for pharmacists is making sure you're giving the right advice. Despite the World Cancer Research Fund's well-publicised research about the carcinogenic properties of processed food, Dr Andrew Wadge, chief scientist at the Food Standards Agency, said this week he would continue to have a bacon sarnie as part of a balanced diet (tinyurl.com/2wg3kw). Wonder if he's partial to a doughnut too?

The Food Standard Agency's chief pharmacist is to continue having **bacon sarnies** as part of his **balanced diet**

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The top stories on the news bulletin

- 1 Struck-off pharmacist was 'serious potential risk'
- 2 RPSGB reveals details of 2008 fees
- 3 Category M cuts were 'right thing to do'
- 4 'Pharmacy minister' hints at white paper
- 5 Pharmacist appointed to Darzi advisory board

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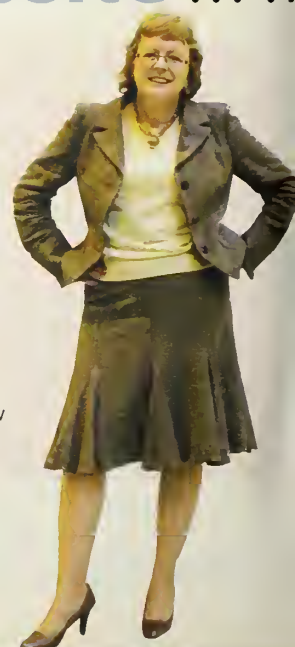
“ Lord Darzi suggested that he would consider any suggestion I have to make. So, I thought I would ask the readers of C+D ”

Lord Darzi's review could have a major impact on pharmacy and the good news is that pharmacy is represented on the panel. But Sandra Gidley, pharmacist and Liberal Democrat MP, wants to know who you want to represent pharmacy in the review. Who would your ideal candidate be?

Go to www.chemistanddruggist.co.uk/bloggists and let Lord Darzi know your thoughts by commenting on Sandra's blog.

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